Telehealth

State(s):	LOB(s):
☒ *Idaho* ☒ *Montana* ☒ *Oregon* ☒ *Washington* ☐ *Other:*	☒ *Commercial* ☒ *Medicare* ☒ *Medicaid*

Enterprise Policy

Clinical Guidelines are written when necessary to provide guidance to providers and members in order to outline and clarify coverage criteria in accordance with the terms of the Member's policy. This Clinical Guideline only applies to PacificSource Health Plans, PacificSource Community Health Plans, and PacificSource Community Solutions in Idaho, Montana, Oregon, and Washington. Because of the changing nature of medicine, this list is subject to revision and update without notice. This document is designed for informational purposes only and is not an authorization or contract. Coverage determination are made on a case-by-case basis and subject to the terms, conditions, limitations, and exclusions of the Member's policy. Member policies differ in benefits and to the extent a conflict exists between the Clinical Guideline and the Member's policy, the Member's policy language shall control. Clinical Guidelines do not constitute medical advice nor guarantee coverage.

Background

This policy describes reimbursement for Telehealth services which occur when a qualified health care professional and member are not at the same site. This policy is meant to outline medical and behavioral health telehealth services. Services regarding dental or other services are addressed in other policies.

General Guidelines and Information

- This is a general reference regarding PacificSource's reimbursement policy for the services described and is not intended to address every reimbursement situation.
- PacificSource recognizes federal and state mandates in regards to Telehealth and Telemedicine. Any terms not otherwise defined in this policy are directed by the federal and state mandates.
- In general, providers rendering services via telehealth must be licensed in each state they are providing care.
- Other factors affecting reimbursement may supplement, modify or supersede this policy which include, but are not limited to the following:
    - Legislative mandates
    - Provider contracts
    - Benefit and coverage documentation
    - Other medical, behavioral health, or drug policies

- This policy may not be implemented exactly the same way as written due to system constraints and limitations; however, PacificSource will attempt to limit these discrepancies.
- Services are subject to medical necessity, evidence-based protocols, and member's eligibility and benefit at time of service.

Criteria

Commercial

Prior authorization to use a telehealth service is not required unless the service requires prior authorization when performed in-person.

Services must meet **ALL** of the following in order to qualify for coverage under the health plan:

- Synchronized video; except where otherwise mandated by state and/or federal law.
- Services must be medically necessary and member must be eligible for coverage.
- Providers and originating site must be eligible for reimbursement.
- Telemedical video and telephonic communication and other consultation services are subject to all terms and conditions of the plan and member benefit.

Eligible Providers: PacificSource recognizes those provider types that are eligible for services in the healthcare setting, are qualified health professionals, who are eligible for reimbursement of appropriate services via telehealth.

Medicaid

PacificSource Community Solutions follows Ancillary Guideline A5 of the OHP Prioritized List of Health Services for coverage of Telehealth and Telemedicine Services.

Medicare

PacificSource follows the Center for Medicare and Medicaid Services (CMS) for coverage of Telehealth and Telemedicine services. Please refer to CMS.gov for coverage criteria.

In addition to what is covered under CMS, PacificSource Medicare allows for Licensed Professional Counselors (LPC), Licensed Marital and Family Therapists (LMFT, Licensed Clinical Professional Counselors (LCPC), Licensed Mental Health Counselors (LMHC), Federally Qualified Health centers (FQHC), and Rural Health Clinics (RHC) to be eligible providers for Tele-video and Telephonic Services as appropriate with state law.

COVID-19 Access to Care and Response to the Disasters and Emergencies

Additional coverage of Telehealth Services which provides additional access to care related to the COVID-19 pandemic.

Subject Area	PacificSource Commercial	PacificSource Medicare	PacificSource Community Solutions and Legacy IDS
Originating Site: Patient Home	Covered	Covered during COVID-19	Covered

Distant Site: Provider Location	Covered	Covered during COVID-19	Adheres to Oregon Health Authority (OHA) OAR 410-120-1990. PCS will follow OHA's Telehealth guidelines as they evolve post state of emergency
Additional Eligible Providers for Tele-video/ Telephonic Services	Covered during COVID-19: Speech Therapists, Occupational Therapists, Physical Therapists *(Please note FQHC and RHC Providers are covered permanently in PacificSource Telehealth policy)*		
Telephonic Services where state regulation is currently prohibited	Covered during COVID-19		
Telehealth Modality such as FaceTime or Skype, during the COVID-19 nationwide public health emergency.	Covered during COVID-19		

Definitions

Telehealth or Telemedicine – consultations with a qualified healthcare professional provided in real-time over an electronic mechanism. These services are rendered to patients using electronic communications such as secure email, patient portals and online audio and/or video conferencing.

E-visits – communication between an established patient and provider through an online patient portal, not in real time.

Virtual Check-In – brief communications between established patients and providers via telephone or other telecommunication devices to decide if an office visit or other services are needed.

Originating Site - the physical location of the patient receiving telemedical health services. Eligible originating sites are limited to:

- Office of a qualified health care professional
- A hospital (Inpatient or Outpatient)
- Critical Access Hospital (CAH)
- Rural Health Clinic (RHC)
- Federal Qualified Health Center (FQHC)
- A hospital based or critical access hospital based renal dialysis center. Independent Renal Dialysis facilities are not eligible originating sites
- Skilled Nursing Facility (SNF)
- Mobile Stroke Unit
- Patient Home (Commercial and Medicaid)

Distant Site – The physical location of the eligible health care provider. Please see Covid-19 Access to Care and Response to the Disasters and Emergencies Section for expanded telehealth coverage, as well as the listed OARs below:

- PacificSource Community Solutions (PCS) adheres to Oregon Health Authority (OHA) OAR 410-120-1990
- Participating providers must comply with Medicaid Network Access standards as outlined in OAR 410-141-3515

Coding Information

Reimbursement Information:

- All Lines of Business
  - Telehealth visits will be subject to retrospective review, as appropriate
- Commercial Line of Business
  - Fees for originating site are ineligible for reimbursement

Claim Information:

- Place of Service (POS) code 02 on CMS HCFA 1500 form will be paid at non-facility RVU for Commercial and Medicaid lines of business and Facility RVU for Medicare line of business.
- Place of Service code 11 for telehealth claims is allowed but must be billed with either the GT or 95 modifier.
- Modifier GT or 95 and additional modifiers may be appended when appropriate to the CPT or HCPCS for telemedicine consultations.
- Documentation for telehealth services should be the same as if services were rendered face-to-face:
  - Document if the service was provided via technology with synchronous audio/video or audio alone.
  - Document where the patient is located and where the provider is located.
  - Document provider is speaking to the correct person (properly identified the person on the call).
  - Consent must also be documented for the visit to be performed via telehealth (can be done annually).
  - Document if the call started out with audio/video but was completed as audio only due to technical issues.
- For additional reimbursement information, please see our COVID-19 Benefit and Reimbursement FAQ at https://medicare.pacificsource.com/Providers/Notice/Index/563

All covered face-to-face services usually done in the office setting, including evaluation and management codes, are eligible to be performed via Tele-video and/or Telephone when criteria is met. Please see current AMA and CMS coding guidelines.

Telehealth Codes:

98966	Telephone assessment and management services provided by a qualified non-physician health care professional to an established patient, parent or guardian not originating from a related assessment and management service provided within the previous seven days nor leading to an assessment and management services or procedure within the next 24 hours or soonest available appointment: 5-10 minutes of medical discussion.
98967	11-20 minutes of medical discussion
98970	Qualified Nonphysician health care professional online digital evaluation and management service, for established patient for up to 7 days, cumulative
98971	Qualified Nonphysician health care professional online digital evaluation and management service, for established patient for up to 7 days, cumulative
98972	Qualified Nonphysician health care professional online digital evaluation and management service, for established patient for up to 7 days, cumulative
99091	Collection & Interpretation Physiologic Data,(e.g. ECG, blood pressure, glucose monitoring) digitally stored &/OR Transmitted, requiring a minimum of 30 minute of time, each 30 days
99421	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days, 5-10 minutes
99422	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days, 11-20 minutes
99423	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days, 21 or more minutes
99441	Telephone evaluation and management services provided by a physician to an established patient, parent or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment: 5-10 minutes of medical discussion.
99442	11-20 minutes of medical discussion
99443	21-30 minutes of medical discussion
99446	Interprofessional telephone/Internet/EHR assessment and management service provided by consultative physician; 5-10 minutes
99447	Interprofessional telephone/Internet/EHR assessment and management service provided by consultative physician; 11-20 minutes
99448	Interprofessional telephone/Internet/EHR assessment and management service provided by consultative physician; 21-30 minutes

99449	Interprofessional telephone/Internet/EHR assessment and management service provided by consultative physician; >31 minutes
99451	Interprofessional telephone/Internet/EHR assessment and management service provided by consultative physician, incl written report to patient's treating physician, 5+ of med consultative time
99452	Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or QHC professional, 30 minutes
99453	Remote monitoring of physiologic parameter(s) (eg weight, blood pressure, pulse oximetry, respiratory flow rate) initial ; set-up and patient education on use of equipment
99454	Remote monitoring of physiologic parameter(s), initial device(s) supply with daily recordings(s) or programmed alert(s) transmission, each 30 days
99457	Remote physiologic monitoring treatment management services, 20 minutes or more of clinical staff/physician time in a calendar month requires interactive communication with the patient/caregiver
99484	Behavioral health condition 20min clinical staff time per calendar month with required assessment/rating scales continuity of care with a designated member of the care team
99487	Complex Chronic Care Coordination Services; first hour with no face-to-face visit, per calendar month
99489	Complex Chronic Care Coordination Services; each additional 30 minutes, per calendar month
99490	Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month
99491	Chronic care management services, provided personally by a physician or other QHC professional, at least 30 minutes of physician or other QHC professional time
99492	Initial psychiatric collaborative care manager 70 min/1 month behavioral health care manager activities in consult with psychiatric consult & directed by treating physician other focused treatment strategies
99493	Subsequent psychiatric collaborative care 60 minutes subsequent month other treatment goals and are prepared for discharge from active treatment
99494	Int/subsequent psychiatric collaborative care manager, each additional 30 minutes/calendar month behavioral health care manager activities in consultation with a psychiatric consultant & directed by treating physician
99495	Transitional Care management Services, moderate complexity, within 14 calendar days

99499	Unlisted Evaluation & management Service
G0406	Follow-up inpatient telehealth consultation, limited, physicians typically spend 15 minutes communicating with the patient via telehealth (modifier GT--Via interactive audio and video telecommunications systems
G0407	Follow-up inpatient telehealth consultation, intermediate, physicians typically spend 25 minutes communicating with the patient via telehealth
G0408	Follow-up inpatient telehealth consultation, complex, physicians typically spend 35 minutes or more communicating with the patient via telehealth
G0425	Telehealth consultation, emergency department or initial inpatient, typically 30 minutes communicating with the patient via telehealth
G0426	Telehealth consultation, emergency department or initial inpatient, typically 50 minutes communicating with the patient via telehealth
G0427	Telehealth consultation, emergency department or initial inpatient, typically 70 minutes communicating with the patient via telehealth
G0459	Inpatient telehealth pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy
Q3014	Telehealth originating site facility fee (ineligible code for commercial)

References

AMA Telehealth policy, coding & payment. (2020, September 24). American Medical Association. https://www.ama-assn.org/practice-management/digital/ama-telehealth-policy-coding-payment

Covid-19 Care Reference Section:

- COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing. (2021, January 7). CMS. https://edit.cms.gov/files/document/medicare-telehealth-frequently-asked-questions-faqs-31720.pdf
- Oregon Health Plan coverage of telephone/telemedicine/telehealth services. (2020, March 20). OHA. https://www.oregon.gov/oha/HSD/OHP/Announcements/Oregon%20Health%20Plan%20coverage%20of%20telemedicine%20services.pdf
- Oregon Mediciad COVID-19 Provider Guide. (2021, April 9). OHA. https://www.oregon.gov/oha/HSD/OHP/Tools/Oregon%20Medicaid%20COVID-19%20Provider%20Guide.pdf

Medicare Telemedicine Health Care Provider Fact Sheet. (2020, March 17). CMS. https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet

Telemedicine Policies. (July 2020). Federation of State Medical Boards. https://www.fsmb.org/siteassets/advocacy/key-issues/telemedicine_policies_by_state.pdf

Appendix

Policy Number:

Effective: 3/1/2020 **Next review:** 5/27/2022

Policy type: Enterprise

Author(s):

Depts: Health Services; Provider Network; Claims

Applicable regulation(s): ORS 743A.058

Commercial Ops: 6/2021

Government Ops: 6/2021